

#### 429 Open Communications 26—Laparoscopy (9:42 AM — 9:47 AM)

##### Laparoscopic Management of Huge Ovarian Cysts

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**Study Objective:** To evaluate the feasibility of laparoscopic management of huge ovarian cysts that reach up to the xiphisternum.

**Design:** Case series of five patients, describing patient's presentation, surgeries performed, complications and final pathology.

**Setting:** The surgeries were performed by the same surgeon in one of two major tertiary care centers in Riyadh, Saudi Arabia.

**Patients:** The patient's age ranged between 19-69 years. All patients presented with abdominal distention and discomfort. The maximum diameter of all cysts as measured by ultrasound ranged between 18-42 cm. Tumor markers were normal for all patients. Ultrasound showed unilocular cysts. In some cases there were fine septations but there were no solid component.

**Intervention:** All patients had open laparoscopy, after evaluation of the cyst capsule, the cysts were drained under laparoscopic guidance, 1-12 liters were drained (mean 5.2 L). Laparoscopic oophorectomy was then performed using the conventional technique. One patient had LAVH and BSO as she was 69 years of age. The procedures were done using three ports only except for the LAVH, where four ports were introduced.

**Measurements and Main Results:** The operative time ranged between 92-125 minutes (mean 106 minutes). There was minimal blood loss and no complications for all the patients. The final pathology confirmed benign serous cystadenoma in four patients and one patient had benign mucinous cystadenoma.

**Conclusion:** Although there is no size limit of ovarian cysts ever been decided to be a contraindication for laparoscopy. With advancing techniques, proper patients selection and availability of experts in gynecologic endoscopy, it is possible to safely remove giant cysts by laparoscopy.

#### 430 Open Communications 26—Laparoscopy (9:48 AM — 9:53 AM)

##### The Incidence of Small Bowel Obstruction after Hysterectomy for Benign Indications

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**Study Objective:** To calculate the incidence of small bowel obstruction (SBO) after hysterectomy for benign indications and to compare the incidence of SBO after laparoscopic (LH), vaginal (TVH), and abdominal (TAH) hysterectomies.

**Design:** Retrospective cohort study with a median (range) follow-up of 16.9 (0-74.6) months.

**Setting:** Tertiary academic U.S. medical center.

**Patients:** 3894 women who underwent hysterectomy for benign disease from 1/2001 through 10/2009.

**Intervention:** SBO was defined as nausea or vomiting with abdominal distention or pain occurring beyond the initial 24 hours of surgery with imaging or surgery confirming obstruction. ICD-9 codes and the electronic medical record were used to identify SBO in our cohort.

**Measurements and Main Results:** Demographics include: mean age 52 (±12.9) years, BMI 28.5 (±10.7), and procedure time 218 (±82)

Table 1  
SBO after hysterectomy

Hysterectomy Type	Small Bowel Obstruction
TVH 34% (n = 1,343)	7/1,343 (0.5%, 95% CI 0.1-0.9%)
TAH 43% (n = 1,671)	9/1,671 (0.5%, 95% CI 0.2-0.9%)
LH 23% (n = 880)	2/880 (0.2%, 95% CI 0-0.5%)
Overall (n = 3,894)	18/3,894 (0.4% 95% CI 0.3-0.6)

minutes. The total incidence of SBO was 18/3,894 (0.4%). See Table 1. Among hysterectomy types, the incidence of small bowel obstruction was not statistically significant. The median latency (range) to presentation of SBO was 0.4 (0-57) months. There were no differences in demographics between those subjects with and without SBO.

**Conclusion:** The incidence of SBO after hysterectomy for benign indications is low. There was no statistically significant difference in SBO incidence after various hysterectomy types.

#### 431 Open Communications 26—Laparoscopy (9:54 AM — 9:59 AM)

##### Total Laparoscopic Hysterectomy: Impact of Uterine Size

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**Study Objective:** To analyze surgical results of women having total laparoscopic hysterectomy to determine whether differences in outcomes exist on the basis of uterine size.

**Design:** This is a level II-2, a case-controlled, retrospective analysis of data from 1,038 consecutive cases of type VII total laparoscopic hysterectomy performed from September 1996 through February 2010. Analyses were done by Pearson's chi-square, Fisher's exact, Wilcoxon rank-sum, and Kruskal-Wallis tests with significance set at two-sided p<0.05.

**Setting:** Four community and teaching hospitals in the Bay Area of California.

**Patients:** Uterine weight was obtained on 974 cases, or 93.8% of the total patient population.

**Intervention:** Outcomes examined include estimated blood loss, skin-to-skin operative times, complications (non-re-operative and re-operative), and duration of hospital stay.

**Measurements and Main Results:** Median operating time varied by uterine weight with a shorter duration of surgery in patients with uteri less than 250 g at 100 minutes (range 30-410), and patients with uteri greater than 250 g at 135 minutes (range 45-336) (p<0.001). Median estimated blood loss was also less in patients with uteri less than 250 g (50 ml), than in patients with uteri weighing 250 g or more (125 ml) (p<0.001). There was no significant difference by uterine weight in median duration of hospital stay (1 day, range 0-13), total complication rate (7.7%), re-operative complications (3.6%), or non-re-operative complications (4.1%). Duration of surgery, volume of blood loss, and length of hospital stay all decreased with the surgeon's increasing experience.

**Conclusion:** Type VII total laparoscopic hysterectomy is feasible and safe, resulting in a short hospital stay, minimal blood loss, minimal operating time, and few complications for patients regardless of uterine weight, and may be to most cost-effective approach.

#### 432 Video Session 13—New Instrumentation and Techniques (9:00 AM — 9:04 AM)

##### Use of a New Rectal Probe in Laparoscopic Pelvic Surgery

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Pelvic surgical interventions that involve rectal dissection such as in endometriosis surgery, oncology procedures or adhesiolysis necessitate rectal identification. This can be done through trans anal introduction of a rectal probe to manipulate the rectum and identify its location. Rectal safety testing to check rectal parietal integrity is mandatory to diagnose rectosigmoid perforation and minimize the risk of fistula formation. These tests require air and coloured solution (blue dye or betadine) injection in the rectum through a transanal rectal catheter. Sterile manipulation and minimizing leakage of air and fluid through the anus are challenging issues in performing this procedure. We developed a disposable rectal probe that can be used for exposure and testing purposes paying attention to reduce manipulation in non sterile environment. This video shows the use of this probe with some tips and